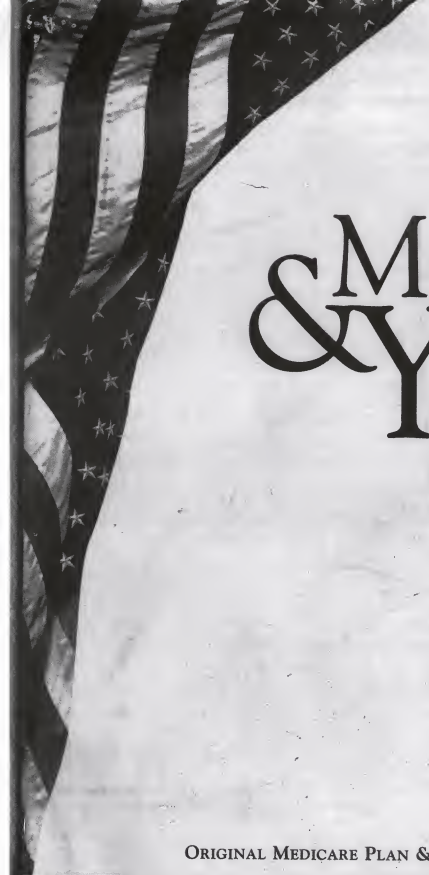

Medicare & You

1999

ORIGINAL MEDICARE PLAN & OTHER MEDICARE HEALTH PLAN CHOICES

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Introduction to *Medicare & You*.....1
What Is the Original Medicare Plan?.....2-5
Part A (Medicare Hospital Insurance) Covered Services.....6
Part B (Medicare Medical Insurance) Covered Services.....7
Medicare Preventive Services.....8
Learning About Medicare Health Plans
Introduction.....9-10
Step 1: Review Your Medicare Health Plan Choices.....11
Step 2: Evaluate What's Important in a Medicare Health Plan.....12-16
Step 3: Review the Medicare Health Plan Choices Available Where You Live.....17
Step 4: Get Information About Available Medicare Health Plan Choices.....18
Step 5: Make the Medicare Health Plan Choice That is Right for You.....18
Step 6: Enrolling/Disenrolling in a Medicare Health Plan.....18
☎ Phone Numbers for Assistance.....19a-d
Worksheet for Comparing Medicare Health Plans.....20-25
Questions and Answers (Q & As) - Other Medicare Health Plans.....25-27
Medicare Patients' Rights.....28
Private Supplemental Insurance Policies.....29-31
Questions and Answers (Q & As) - Original Medicare Plan.....32-34
Protect Yourself Against Discrimination, Fraud, and Abuse.....35
Index.....36

Railroad Retirement Beneficiaries: The Railroad Retirement Board (RRB) helps the Health Care Financing Administration (HCFA) administer certain aspects of the Medicare program for beneficiaries covered under the Railroad Retirement Act. Railroad Retirement beneficiaries should contact their local RRB office for answers to Medicare questions. Railroad Retirement beneficiaries can find their local office by calling 1-800-808-0772. Additional information about Medicare for Railroad Retirement beneficiaries is available on the Internet at **www.rrb.gov.**

Comments: HCFA welcomes your comments and suggestions about *Medicare & You.* HCFA will be unable to respond to you directly, but your comments may help us make improvements to future versions of this handbook.

Send your comments to: Health Care Financing Administration
Medicare & You Comments
7500 Security Blvd.
Baltimore, MD 21244-1850

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

Medicare & You explains the Medicare Program, but it is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Dear Medicare Beneficiaries:

Recent legislation included Medicare+Choice, which will result in changes to the Medicare program. This new legislation will help keep Medicare well funded. Importantly, you now have new preventive health benefits and new patient protections. In addition, starting in 1999, Medicare will offer new health plan choices. You may want to look at these choices.

To help you understand these changes, we have revised *Your Medicare Handbook* and given it a new name — *Medicare & You.* It includes a description of the new preventive benefits available to you (see page 8), the rights you have as a patient (see page 28), and the new health plan options available to you (see pages 9-18). It will help you identify some of the important questions you will want to ask and includes a list of important resources for you to use to get more information (see pages 19a-d). Medicare information is also available on the Internet at **www.medicare.gov**. If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.

As you read this handbook, it is very important for you to remember that *if you are happy with the way you get your health care now, you don't have to do anything.* The choice is yours. No matter what you decide, you are still in the Medicare program and will receive all the Medicare covered services.

It is also important to remember that Medicare doesn't pay for everything, and Medicare doesn't cover everything. To get more coverage, you may purchase a Medicare Supplemental Insurance Policy (see pages 29-30), or you may consider joining a different health plan that may provide extra benefits.

If you are interested in changing the way you receive your care, one of the new choices may be right for you. **Caution:** Changing the way you receive your health care is an important decision. You may wish to ask your family, friends, or doctor for help. Special rules may apply if you choose to disenroll from a Medicare health plan and return to the Original Medicare Plan with a Supplemental Insurance Policy (see page 26). If you or your spouse has health care coverage that supplements Medicare through a former employer or union, contact your benefits representative before you make a new health plan choice. If you have Medicaid coverage, do not make changes until you contact the State Medical Assistance Office.

Whether you are new to the Medicare program or not, we want you to know of our deep commitment to keep Medicare working for you.

Donna E. Shalala
Donna E. Shalala
Secretary, Department of Health and Human Services

Nancy-Ann Min DeParle
Nancy-Ann Min DeParle
Administrator, Health Care Financing Administration

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A. (Benefit periods are explained on page 6.)
- each year for Part B.

Coinsurance:
The percent of the approved charge that you have to pay:
- after you pay the Part A deductible. (see page 6)
- after you pay the first $100 deductible each year for Part B.

Premium:
Monthly payment for health care coverage to:
- Medicare,
- an insurance company, or
- a health care plan.

Fiscal Intermediary:
A private insurance company that has contracted with Medicare to process bills (claims) for Part A services.

☎ - When you see this symbol, the telephone number for the person you need to contact can be found on page 19a-d.

Medicare Is a Health Insurance Program for:

- People 65 years of age and older.
- Certain younger people with disabilities.
- People with End-Stage Renal Disease (people with permanent kidney failure who need dialysis or a transplant).

What Is the Original Medicare Plan?

The Original Medicare Plan is the traditional pay-per-visit arrangement (see pages 6-8). You can go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the **deductible**. Then Medicare pays its share, and you pay your share (**coinsurance**). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). If you are in the Original Medicare Plan now, the way you receive your health care will not change unless you enroll in another Medicare health plan.

What Is Part A (Hospital Insurance)?

Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible, Part A is **premium** free—that is, you don't pay a premium because you or your spouse paid Medicare taxes while you were working. Your **Fiscal Intermediary** can answer your questions on what Part A services Medicare will pay for and how much will be paid (☎).

You are eligible for premium-free Medicare Part A (Hospital Insurance) if:

- You are 65 or older. You are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65. You have received Social Security disability benefits for 24 months, or
- You are under 65. You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease.

If you don't qualify for premium-free Part A, and you are 65 or older, you may be able to buy it. (Contact the Social Security Administration (☎).)

What Is Part B (Medical Insurance)?

Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B covers all doctor services that are medically necessary. Beneficiaries may receive these services anywhere (a doctor's office, clinic, nursing home, hospital, or at home). Your **Medicare carrier** can answer questions about Part B services and coverage (☎).

Medicare carrier:
A private insurance company that has contracted with Medicare to process beneficiary bills (claims) for Part B services.

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older. Part B cost $43.80 per month in 1998.*

Part B is voluntary. If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. Beneficiaries who do not receive any of the above payments are billed by Medicare every 3 months.

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods:

- **General Enrollment Period:** If you didn't take Part B, you can only sign up during the general enrollment period, January 1 through March 31 of each year. Your Part B coverage is effective July 1. Your monthly Part B premium may be higher. The Part B premium increases 10% for each 12-month period that you could have had Part B but did not take it.
- **Special Enrollment Period:** If you didn't take Part B because you or your spouse currently work and have group health plan coverage through your current employer or union, you can sign up for Part B during the special enrollment period. Under the special enrollment period, you can sign up at any time you are covered under the group plan. In addition, if the employment or group health coverage ends, you have 8 months to sign up. The 8-month period starts the month after the employment ends or the group health coverage ends, whichever comes first. Generally, your monthly Part B premium is not increased when you sign up for Part B during the special enrollment period. Contact the Social Security Administration, or the Railroad Retirement Board to sign up for Part B (☎).

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at **www.medicare.gov**.

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A. (Benefit periods are explained on page 6.)
- each year for Part B.

Coinsurance:
The percent of the approved charge that you have to pay:
- after you pay the Part A deductible. (see page 6)
- after you pay the first $100 deductible each year for Part B.

Copayment:
In some health plans, the amount you pay for each medical service, like a doctor visit.

Medicaid:
A joint Federal and State program that provides medical help for certain individuals with low incomes and limited resources (see page 33).

What Are Your "Out-of-Pocket" Costs?

The Original Medicare Plan pays for much of your health care, but not all of it. Your "out-of-pocket" costs for health care will include your monthly Part B premium. In addition, when you get health care services, you will also have to pay deductibles and coinsurance or copayments. Generally, you will pay for your outpatient prescription drugs. You also pay for routine physicals, custodial care, most dental care, dentures, routine foot care, or hearing aids. Physical therapy and occupational therapy services, except for those you get in hospital outpatient departments, are subject to annual limits. The Original Medicare Plan does pay for some preventive care, but not all of it.

Your Out-of-Pocket Costs May Depend On:

- Whether your doctor accepts assignment.
- How often you need health care.
- What type of health care you need.

If You Choose Another Medicare Health Plan or Purchase a Supplemental Policy, Out-of-Pocket Costs May Also Depend On:

- Which Medicare health plan you choose.
- What extra benefits are covered by the plan.
- What your supplemental health insurance covers.

Help for Low-Income Medicare Beneficiaries

For certain older, low-income, or disabled individuals entitled to Medicare Part A, your State Medicaid program will pay some or all of Medicare's premiums, and may also pay Medicare's deductibles and coinsurance if you have Part A, and your bank accounts, stocks, bonds, or other resources do not exceed $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance. If you think you may qualify, contact your State, county, or local medical assistance office (☎). (Income limits will change slightly in 1999.) See page 33.

What Is Assignment?

In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (You are still responsible for any coinsurance amount.) **Doctors who don't accept assignment can require you to pay the full amount of the bill at the time of service.** Medicare will then reimburse you for its share of the bill. **Always ask your doctors and medical suppliers whether they accept assignment of Medicare claims.** That could mean savings for you.

For a list of the doctors and medical suppliers in your area who accept assignment, call your Medicare carrier (☎).

In certain situations, all doctors and medical suppliers are required to accept assignment. For instance, all doctors and qualified laboratories must accept assignment for clinical laboratory services covered by Medicare. Doctors also must accept assignment if you are low-income and Medicaid pays your Medicare coinsurance.

Limiting Charge:
The maximum amount a doctor can charge a Medicare beneficiary for a covered service if the doctor doesn't accept assignment. The limit is 15% over Medicare's approved payment amount.

Doctors and other health care providers who don't accept assignment may not charge more than 15% over Medicare's approved payment amount (the **limiting charge**). The limiting charge does not apply to services you get from doctors with whom you have a private contract (see page 32), or for certain items and services, such as durable medical equipment, ambulance services, vaccinations, and anti-nausea drugs that are covered by Medicare. Contact your Medicare carrier with questions (☎).

For example, assume that your $100 Part B deductible has been paid for the year. You receive a medical service and the Medicare-approved payment amount for the service is $100. If your doctor accepts assignment, the most you would pay is $20. If the doctor does not accept assignment, the most you would pay is $33.25 after Medicare pays its share of the bill.

What are Medicare covered services?

The next three pages explain the services covered in the Original Medicare Plan. Medicare doesn't pay for everything, and Medicare doesn't cover everything. To get more coverage, you may purchase a Medicare Supplemental Insurance Policy (see pages 29-31) or you may consider joining a different Medicare health plan that may provide extra benefits (see pages 9-18).

All Medicare health plans must provide all Medicare covered services described on pages 6-8.

Medicare Part A (Hospital Insurance) Covered Services

Covered Services	What You Pay*
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in your room, or a private room unless medically necessary).	**For each benefit period you pay:** ■ A total of $764 for a hospital stay of 1-60 days. ■ $191 per day for days 61-90 of a hospital stay. ■ $382 per day for days 91-150 of a hospital stay.** ■ All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care†: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies. More information on SNFs can be found on page 34.	**For each benefit period you pay:** ■ Nothing for the first 20 days. ■ Up to $95.50 per day for days 21-100. ■ All costs beyond the 100th day in the benefit period. Contact your Fiscal Intermediary with questions about Skilled Nursing Facility Care and conditions of coverage (☎).
Home Health Care†: Intermittent skilled nursing care, physical therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**You pay:** ■ Nothing for Home Health Care services. ■ 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Call your Regional Home Health Intermediary with questions about Home Health Care and conditions of coverage (☎).
Hospice Care†: Pain and symptom relief, and supportive services for the management of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services otherwise not covered by Medicare.	**You pay:** ■ Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual care giver can rest). Call your Regional Home Health Intermediary with questions about Hospice Care and conditions of coverage (☎).
Blood: From a hospital or skilled nursing facility during a covered stay.	**You pay:** ■ For the first 3 pints.

*1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1, 1999.

**You have 60 reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance ($382 in 1998).

†You must meet certain conditions in order for Medicare to cover these services.

Benefit Period: Starts the day you are admitted to a hospital or Skilled Nursing Facility and ends when you haven't received hospital inpatient or Skilled Nursing Facility care for 60 consecutive days.

Call your Fiscal Intermediary for general questions about your Medicare Part A coverage (☎).

Medicare Part B (Medical Insurance) Covered Services

Covered Services	What You Pay*
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	**You pay:** ■ $100 deductible (pay once per year). ■ 20% of approved amount after the deductible, except in the outpatient setting. ■ 50% for most outpatient mental health. ■ 20% of first $1,500 for all physical therapy services and 20% of first $1,500 for all occupational therapy services, and all charges thereafter. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** ■ Nothing for services.
Home Health Care: (If you don't have Part A.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	**You pay:** ■ Nothing for services. ■ 20% of approved amount for DME.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** ■ No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	**You pay:** ■ For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

*The 1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1, 1999.

Note: Actual amounts you must pay for coinsurance are higher if the doctor does not accept assignment (see page 5).

Call your Medicare carrier if you have general questions about your Medicare Part B coverage (☎).

Part B also helps pay for:

- X-rays
- Speech language pathology services
- Artificial limbs and eyes
- Arm, leg, back, and neck braces
- Kidney dialysis and kidney transplants
- Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility
- Preventive services (see next page)
- Very limited outpatient drugs
- Emergency care
- Limited chiropractic services
- Medical supplies: items such as ostomy bags, surgical dressings, splints, and casts
- Breast prostheses following a mastectomy
- Ambulance services (limited coverage)
- The services of practitioners such as clinical psychologists, clinical social workers, and nurse practitioners
- One pair of eyeglasses after cataract surgery with an intraocular lens

Medicare Preventive Services - Added Benefits to Help You Stay Healthy

Covered Service	Eligible Beneficiaries	What You Pay
Screening Mammogram: Once per year.	All female Medicare beneficiaries age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once per year if you are high risk for cancer of the cervix or had an abnormal Pap smear in the preceding three years.	All female Medicare beneficiaries.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Colorectal Cancer Screening: **Fecal Occult Blood Test** Once every year. **Flexible Sigmoidoscopy** Once every four years. **Colonoscopy** Once every two years if you are high risk for cancer of the colon. **Barium Enema** Doctor can substitute for sigmoidoscopy or colonoscopy.	All Medicare beneficiaries age 50 and older.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the annual Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare approved amount after the annual Part B deductible.
Bone Mass Measurements: Varies with your health status.	Certain Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare approved amount after the annual Part B deductible.
Vaccinations: **Flu Shot:** Once per year. **Pneumococcal Vaccination:** One may be all you ever need - ask your doctor. **Hepatitis B Vaccination:** If you are high risk for hepatitis.	All Medicare beneficiaries.	No coinsurance and no Part B deductible for flu or pneumococcal vaccinations. For Hepatitis B vaccination, 20% of the Medicare approved amount after the Part B deductible.

Introduction to Learning About Medicare Health Plans ▶

If you are happy with the way you get health care now, you don't have to do anything. If you do nothing, you will continue to receive your Medicare health care in the same way you always have.

More Medicare Health Plan Choices

Starting in 1999, Medicare offers more health plan choices. One of the new health plan choices might be right for you. The choice is yours. No matter what you decide, you are still in the Medicare program. All Medicare health plans must provide all Medicare covered services described on pages 6-8.

To be eligible for the other Medicare health plan choices*:

- You must have Part A (Hospital Insurance) and Part B (Medical Insurance).
- You must not have End-Stage Renal Disease. (ESRD is permanent kidney failure that requires dialysis or a transplant.) However, ESRD beneficiaries currently in a health plan will be able to remain in the plan they are in.
- You must live in the service area of a health plan. The service area is the geographic area where the plan accepts enrollees. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area. **If you are disenrolled, you are automatically covered under the Original Medicare Plan.** You can also choose to join a Medicare health plan in your new area.

Your out-of-pocket costs may depend on:

- Which Medicare health plan you chose.
- How often you need health care.
- What type of health care you need.
- Which extra benefits are covered by the plan.
- What your supplemental health insurance covers.
- Whether your doctor accepts assignment (Original Medicare Plan only).

*All health plan choices may not be available in your area. For the most current list of your local Medicare health plan choices, look at the Internet at **www.medicare.gov**.

Have you heard that Medicare now offers more health plan choices?

Different health plan choices may affect your:

Cost:
What you pay.

Extra Benefits:
What extra benefits you get, like prescription drugs.

Providers:
How much choice you have among doctors, and hospitals, and other health care providers.

Steps 1 - 6 are on the following pages.

Understand Your Medicare Health Plan Choices

Medicare has new health plan choices.

If you want to learn about the new health plan choices, please keep reading. Think about your current health care needs or the needs you may have in the future. Consider how each health plan would meet your needs. **No matter what you decide, you are still in the Medicare program. You will continue to receive at least all the Medicare covered services** (see pages 6-8).

If you are happy with the way you get health care now, you don't have to do anything! If you do nothing, the way you receive your health care now will not change.

If you want to look at the choices, the steps below will help you compare your Medicare health plan choices.

Steps to Choosing a Health Plan:

Step 1: Review your Medicare health plan choices.

Step 2: Evaluate what's important in a Medicare health plan.

Step 3: Review the Medicare health plan choices available where you live.

Some plans only cover certain zip codes within a county. You should contact the plan to verify that it is available in your zip code.

Step 4: Get information about available Medicare health plan choices.

Step 5: Make the Medicare health plan choice that is right for you.

Step 6: Enrolling/Disenrolling in a Medicare health plan.

Step 1: Review Your Medicare Health Plan Choices

All of the Medicare health plan choices are listed below. However, they may not all be available in your area.

- The Original Medicare Plan
- The Original Medicare Plan with a Supplemental Insurance Policy
- Medicare Managed Care Plans
  - Health Maintenance Organizations (HMOs)
  - HMOs with Point of Service Option (POS)
  - Provider Sponsored Organizations (PSOs)
  - Preferred Provider Organizations (PPOs)
- Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans (MSAs)
- Religious Fraternal Benefit Society Plans (RFBs)

These health plan choices are explained on pages 14-16.

Caution

If you answer yes to any of these questions, your health plan choices may be different or better.

If you answer yes to this question...	Please follow the instructions...
☐ Are you (or your spouse) retired? Do you have health insurance through the former employer or union?	Contact your former employer or union before you make a health plan choice.
☐ Are you (or your spouse) still working? Do you have health insurance through the employer or union?	Contact your or your spouse's employer or union before you make a health plan choice.
☐ Do you have Medicaid or is your income low enough that you may qualify for Medicaid?	Contact your State Medical Assistance Office (☎). (Information on Medicaid is on page 33.)
☐ Are you a military retiree?	Contact your local military base.
☐ Are you a veteran entitled to Veterans Administration (VA) benefits?	Contact your local Veterans Administration office.
☐ Do you have End-Stage Renal Disease (ESRD)?	You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see page 29).
☐ Do you have only Medicare Part A or only Part B?	You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see page 29).

Step 2: Evaluate What's Important in a Medicare Health Plan

Remember: The Original Medicare plan doesn't pay for or cover everything. To get more coverage, you may purchase a Supplemental Insurance Policy, or you may consider joining a Medicare Managed Care Plan or Private Fee-for-Service Plan. Another choice is the Medicare Medical Savings Account (MSA) Plan (see "Enrolling (Disenrolling) in a Medicare Health Plan" on page 18). You should look at how all the health plan choices differ on cost, choice of doctors and hospitals, and benefits.

Cost

What you pay:

- All beneficiaries pay the Part B premium of $43.80 (in 1998).
- Monthly premiums tend to be lower in Medicare Managed Care Plans (if you follow the plan rules) than in most Supplemental Insurance Policies and some Private Fee-for-Service Plans.
- Your out-of-pocket costs (what you must pay) tend to be lower in most Managed Care Plans and the Original Medicare Plan with some Supplemental Insurance Policies. Costs often are higher in the Original Medicare Plan without a Supplemental Insurance Policy.
- In Medicare MSA Plans, there is no monthly premium. You pay for all the costs of services prior to meeting the high deductible for your plan. Your Medicare MSA can help pay the costs of services prior to your meeting the high deductible (page 16).
- In Private Fee-for-Service Plans and Medicare MSA Plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Providers

How you choose doctors and hospitals:

- The Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and certain Medicare MSA Plans have the widest choice of doctors and hospitals.
- In most Medicare Managed Care Plans, and in some Medicare MSA Plans, you must choose your doctors and hospitals from a list provided by the plan. You may want to check if your current doctor is on the plan's list, and is accepting new Medicare patients under that plan. There is no guarantee that a particular doctor will stay with the plan.
- You can go to any specialist who accepts Medicare in the Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and some Medicare MSA Plans. Most Medicare Managed Care Plans and some Medicare MSA Plans require a referral from your primary care doctor for you to see a specialist.
- In Private Fee-for-Service Plans and Medicare MSA plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Extra Benefits - What Services You Get

- In Medicare Managed Care Plans or Private Fee-For-Service Plans, you may get extra benefits, like vision or dental care — beyond the benefits covered by the Original Medicare Plan or the Original Medicare Plan with a Supplemental Insurance Policy. In lieu of extra benefits, enrollees in Medicare MSA Plans receive a deposit in their Medicare MSA from Medicare. See comparison charts on page 17, or look on the Internet at www.medicare.gov for more information.

Prescription Drugs - An Important Extra Benefit

- In general, the Original Medicare Plan does not cover outpatient prescription drugs. Many Medicare Managed Care Plans and a few of the more expensive Supplemental Insurance Policies cover certain prescription drugs up to a specified dollar limit. In general, the Original Medicare Plan only covers medication while you are in a hospital or skilled nursing facility.

Other Important Things To Think About

- In the Original Medicare Plan, Medicare pays doctors and other healthcare providers directly for each service that you receive. For all other Medicare health plans, Medicare pays the health plan a lump sum amount of money; the plan oversees the services you receive.
- Plan benefits and costs can change each year. These changes are usually effective the first day of the new year.
- Medicare health plans may terminate their contract with Medicare at any time. If the plan terminates its contract with Medicare, you would be notified by the plan and automatically returned to the Original Medicare Plan. See page 32 for information on how this would affect your ability to get a Supplemental Insurance Policy should you want to stay with the Original Medicare Plan. You may join another plan in the area, but you will be covered by the Original Medicare Plan until the new coverage is in effect.
- Except for Medicare MSA Plans, you may leave (disenroll from) most Medicare health plans at any time and either return to the Original Medicare Plan, or switch to another plan. Special rules may apply if you choose to return to your Supplemental Insurance Policy or your employer's health insurance (see page 26). Contact your State Health Insurance Advisory Program, your State Insurance Department, or your employer for more information (☎).
- As a Medicare beneficiary, you have rights. All Medicare health plans are required to have an appeal and grievance (complaint) process and must respond to your concerns (see pages 27 and 28).

Original Medicare Plan ▶
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Original Medicare Plan

The Original Medicare Plan is the traditional system, run by the Federal government, that covers your Part A and Part B services. Medicare pays its share of the bill and you pay the balance.

Cost: You pay the $43.80* Part B premium, Part A and Part B deductibles, and the coinsurance.

Providers: You can go to any doctor or hospital that accepts Medicare.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8, but no extra benefits.

Original Medicare Plan With a Supplemental Policy ▶
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. You can buy a supplemental Insurance Policy for extra benefits that help cover some of your out-of-pocket costs.

Original Medicare Plan with a Supplemental Policy

The Original Medicare Plan is the traditional system that covers your Part A and Part B services. Medicare pays its share of the bill, and you pay the balance. You may purchase one of ten standard Supplemental Insurance Policies (Medigap or Medicare SELECT) for extra benefits (see pages 29 - 30). Some policies help pay Medicare's coinsurance amounts and deductibles.

Cost: You pay the Part B premium of $43.80*. You also pay an additional monthly premium for your Supplemental Insurance Policy. The premium varies by State and insurer, and often varies by age. Most policies pay Medicare's coinsurance amounts and some also pay for Medicare's deductibles.

Providers:

- **Medigap:** You can go to any doctor or hospital that accepts Medicare.
- **Medicare SELECT:** You must use plan hospitals and in some cases plan doctors in order to be eligible for full Medigap benefits.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8. Some Supplemental Policies also cover services the Original Medicare Plan doesn't (see pages 29 - 30).

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at **www.medicare.gov**.

Managed Care Plans ▶
A group of health plans that include:

HMO:
Health Maintenance Organization

POS:
HMO with a Point of Service Option

PSO:
Provider Sponsored Organization

PPO:
Preferred Provider Organization

Private Fee-for-Service Plan ▶
A private insurance plan that accepts Medicare beneficiaries.

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at **www.medicare.gov**.

Managed Care

A Managed Care Plan involves a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed Care Plans include **HMOs**, HMOs with a **POS** option, **PSOs**, and **PPOs**.

Cost: You pay the Part B premium of $43.80.* Some plans charge you an extra monthly premium. You may also pay the plan a copayment per visit or service. You will also pay more if you don't follow plan rules. No Supplemental Insurance Policy is necessary if you join a Managed Care Plan (see page 29).

Providers: Your choice of doctors and hospitals varies by the type of Medicare Managed Care Plan you choose. HMOs and PSOs are usually more restrictive - you must use the plan's doctors and hospitals. PPOs and HMOs with POS options are generally less restrictive - you may use doctors and hospitals outside of the plan for an additional cost.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8. Many Medicare Managed Care Plans offer additional benefits not covered under the Original Medicare Plan.

Private Fee-for-Service Plan

You choose a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to reimburse for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover.

Cost: You pay the Part B premium of $43.80*, any monthly premium the Private Fee-for-Service Plan charges, and an amount per visit or service. Providers are allowed to bill beyond what the plan pays, and you will be responsible for paying whatever the plan doesn't cover. You may pay more for services.

Providers: You can go to any doctor or hospital.

Extra Benefits: You receive all the Medicare covered services listed on pages 6 - 8. Some Private Fee-for-Service Plans may offer additional benefits that the Original Medicare Plan doesn't cover.

Medicare Medical Savings Account (MSA) Plan ▶
A test program for 390,000 Medicare beneficiaries. If you choose a Medicare MSA Plan, you must stay in it for a full year. Medicare MSA Plans first become available in November 1998.

Medicare Medical Savings Account (MSA) Plan

This is a test program for 390,000 eligible Medicare beneficiaries. You choose a Medicare MSA Plan – a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA Plan and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay for medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but that money will be taxed. **If you enroll in a Medicare MSA Plan, you must stay in it for a full year.** You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Call 1-800-318-2596 for more information on Medicare MSA Plans. Medicare MSA Plans first become available in November 1998.

Cost: You pay the Part B premium of $43.80.* You use the money in your Medicare MSA to pay for medical expenses. Unlike other Medicare health plans, there are no limits on what providers can charge you above the amount paid by your Medicare MSA Plan. If you use all your Medicare MSA money, you are responsible for paying all of your medical expenses until you meet the deductible for your Medicare MSA Plan. The deductible can be considerably higher than those of other Medicare health plans. Your Medicare MSA can help pay these costs.

Providers: Depending on the Medicare MSA Plan you choose, you may be able to go to any doctor or hospital, or you may be limited to a network of providers.

Extra Benefits: Money in your Medicare MSA pays for things that the Original Medicare Plan covers, plus other services it does not cover. A Medicare MSA Plan may offer additional benefits the Original Medicare Plan doesn't cover, but it doesn't pay for them until you meet your annual deductible.

Religious Fraternal Benefit Society Plans ▶

Religious Fraternal Benefit Society Plans

These plans are offered by a Religious Fraternal Benefit Society for members of the society. Only members of the society may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

*The Social Security Administration or the Railroad Retirement Board will send you information about the 1999 Part A and Part B premium rates by January 1, 1999. Or you can check the Internet at **www.medicare.gov**.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	Original Medicare Plan	Original Medicare Plan with Supplemental Policy	Clark County Kaiser Foundation Health Plan of the NW (SHMO***)—1A
BASIC PLAN INFORMATION			Senior Advantage II. SHMO/Non-Profit/1(503)813-2000.
COST Premium (does not include Part B Premium)			You pay $170 a month if you have Medicare Parts A and B.
Physican Visits	You pay 20%*		You pay $5 per visit with your personal physician.
Inpatient Hospital	You pay $764 for day 1-60, $191 each for days 61-90, and $382 each day for days 91-150.**		You pay nothing for your hospital stay. Additional hospital charges apply.
DOCTOR CHOICE	You may see any doctor, specialist, or provider who accepts Medicare.		You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.
PRESCRIPTION DRUGS	Prescription drugs are not covered.		Prescription drugs are covered with limits. You pay $5 per prescription. You must use plan-approved prescription drugs.
EXTRA BENEFITS Physical Exams	Routine physical exams are not covered.		You are covered for an unlimited number of physical exams per year.
Vision Services	Vision services not covered except for cataract related benefits.		You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	Dental services are not covered.		In general, you are not covered for dental services.

See pages 29-30

*Each year, you are responsible for ONE $100 deductible toward all these benefits.
** If you have exhausted your 60 lifetime reserve days (see page 6).
For more choices, see next page.

*** Social Health Maintenance Organization (SHMO)—Provides the full range of Medicare benefits and additional services, such as care coordination, chronic care benefits, and home- and community-based services.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	Clark County PacifiCare of Washington—4A	Clark County Regence Health Maintenance of Oregon—1A	Cowlitz & Lewis Counties PacifiCare of Washington—1A
BASIC PLAN INFORMATION	Secure Horizons. HMO/For Profit/1(800)533-2743.	Basic Plan. HMO/For Profit/1(800)541-8981.	Secure Horizons. HMO/For Profit/1(800)255-6673.
COST			
Premium (does not include Part B Premium)	You pay $39 a month if you have Medicare Parts A and B.	You pay $15 a month if you have Medicare Parts A and B.	You pay nothing if you have Medicare Parts A and B.
Physican Visits	You pay $10 per visit with your personal physician.	You pay $10 per visit with your personal physician.	You pay $5 per visit with your personal physician.
Inpatient Hospital	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.
DOCTOR CHOICE	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.
EXTRA BENEFITS			
Physical Exams	You are covered for an unlimited number of physical exams per year.	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	In general, you are not covered for dental services.	In general, you are not covered for dental services.	In general, you are not covered for dental services.

For more choices, see next page.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	Lewis County Group Health Cooperative of Puget Sound—2A	Lewis County Group Health Cooperative of Puget Sound—2B	Lewis County HealthPlus—1A
BASIC PLAN INFORMATION	Group Health Medicare. HMO/Non-Profit/1(206)901-4600.	Group Health Medicare. HMO/Non-Profit/1(206)901-4600.	Senior Partners. HMO/Non-Profit/1(800)551-9903.
COST			
Premium (does not include Part B Premium)	You pay $29 a month if you have Medicare Parts A and B.	You pay $48 a month if you have Medicare Parts A and B.	You pay nothing if you have Medicare Parts A and B.
Physican Visits	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.
Inpatient Hospital	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.
DOCTOR CHOICE	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.
EXTRA BENEFITS			
Physical Exams	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	In general, you are not covered for dental services.	You are covered for 2 preventive dental exams every 1 year(s). You pay nothing per preventive dental exam.	In general, you are not covered for dental services.

For more choices, see next page.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	Lewis County Options Health Care Inc.—2A	Lewis County Options Health Care Inc.—2B	Lincoln & Spokane Providence Health Plan—2A
BASIC PLAN INFORMATION	Options Health Care Medicare. HMO/For Profit/1(206)442-4085.	Options Health Care Medicare. HMO/For Profit/1(206)442-4085.	Providence Medicare Extra. HMO/Non-Profit/1(800)457-6064.
COST			
Premium (does not include Part B Premium)	You pay $29 a month if you have Medicare Parts A and B.	You pay $54 a month if you have Medicare Parts A and B.	You pay $60 a month if you have Medicare Parts A and B.
Physican Visits	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.	You pay $10 per visit with your personal physician.
Inpatient Hospital	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.
DOCTOR CHOICE	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You may use non-plan doctors. You don't need a referral to see specialists.	You may use non-plan doctors. You need a referral to see specialists.
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.
EXTRA BENEFITS			
Physical Exams	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	In general, you are not covered for dental services.	You are covered for 2 preventive dental exams every 1 year(s). You pay nothing per preventive dental exam.	In general, you are not covered for dental services.

For more choices, see next page.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	North Central Counties Providence Health Plan—1A	Pend Oreille & Spokane PacifiCare of Washington—2A	Southwestern Counties Kaiser Foundation Health Plan of the NW—1A
BASIC PLAN INFORMATION	Providence Medicare Extra. HMO/Non-Profit/1(800)457-6064.	Secure Horizons. HMO/For Profit/1(800)255-6673.	Senior Advantage. HMO/Non-Profit/1(503)813-2000.
COST			
Premium (does not include Part B Premium)	You pay $60 a month if you have Medicare Parts A and B.	You pay nothing if you have Medicare Parts A and B.	You pay $75 a month if you have Medicare Parts A and B.
Physican Visits	You pay $10 per visit with your personal physician.	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.
Inpatient Hospital	You pay $100 per admission to a plan hospital.	You pay nothing for your hospital stay.	You pay nothing for your hospital stay. Additional hospital charges apply.
DOCTOR CHOICE	You may use non-plan doctors. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	Prescription drugs are covered with limits. You pay 70% per prescription. You must use plan-approved prescription drugs.
EXTRA BENEFITS			
Physical Exams	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.	You are covered for an unlimited number of physical exams per year.
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	In general, you are not covered for dental services.	In general, you are not covered for dental services.	In general, you are not covered for dental services.

For more choices, see next page.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

WHAT'S MOST IMPORTANT TO YOU	Spokane County Group Health Northwest—1A	Spokane County Medical Service Corp of Eastern Washington—1A	Spokane County QualMed Plans for Health, Inc.—1A
BASIC PLAN INFORMATION	Standard Risk Plan. As Submitted. HMO/Non-Profit/1(509)459-9100.	Classic Care. HMO/Non-Profit/1(800)287-4097.	Senior Security—Standard Plan. HMO/For Profit/1(800)695-5063.
COST			
Premium (does not include Part B Premium)	You pay $49 a month if you have Medicare Parts A and B.	You pay nothing if you have Medicare Parts A and B.	You pay $39 a month if you have Medicare Parts A and B.
Physican Visits	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.	You pay $5 per visit with your personal physician.
Inpatient Hospital	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.	You pay nothing for your hospital stay.
DOCTOR CHOICE	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.
EXTRA BENEFITS			
Physical Exams	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.	You are covered for 1 physical exam(s) per year.
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.
Dental	In general, you are not covered for dental services.	In general, you are not covered for dental services.	In general, you are not covered for dental services.

For more choices, see next page.

Contact the Plan to verify that it is available in your zip code.

1999 Plan Information—Southwest and Eastern Washington

	Walla Walla		
WHAT'S MOST IMPORTANT TO YOU	**PacifiCare of Washington—3A**		
BASIC PLAN INFORMATION	Secure Horizons. HMO/For Profit/1(800)255-6673.		
COST			
Premium (does not include Part B Premium)	You pay $22 a month if you have Medicare Parts A and B.		
Physican Visits	You pay $5 per visit with your personal physician.		
Inpatient Hospital	You pay nothing for your hospital stay.		
DOCTOR CHOICE	You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists.		
PRESCRIPTION DRUGS	You pay 100% for most prescription drugs.		
EXTRA BENEFITS			
Physical Exams	You are covered for 1 physical exam(s) per year.		
Vision Services	You have some coverage for glasses, contacts, and routine eye exams—contact plan for details.		
Dental	In general, you are not covered for dental services.		

STEP 4: Get Information About Available Medicare Health Plan Choices

Now that you have looked at your health plan choices, you can get more detailed information about the health plans by: □ calling the health plan or □ checking the Internet at **www.medicare.gov** or □ calling 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048. Have the number on your Medicare Card (red, white, and blue card) ready. For more detailed information about Medicare Supplemental Policies, get a copy of the *Guide to Health Insurance for People With Medicare* (☎).

STEP 5: Make the Medicare Health Plan Choice That is Right for You

You may want to talk with family, friends, or your doctor about your health plan choices before making a final decision. You may also call your State Health Insurance Advisory Program for assistance (☎). For more help, please see the worksheet on pages 20-25.

STEP 6: Enrolling (Disenrolling) in a Medicare Health Plan

You don't need to do anything if you want to keep the Original Medicare Plan or your current Medicare Managed Care Plan. If you have another health plan, you must disenroll to return to Original Medicare.

How to enroll/disenroll: Medicare Managed Care or Private Fee-for-Service Plan

You can enroll in a Medicare Managed Care Plan or a Private Fee-for-Service Plan at any time.

To enroll:

- Call the plan to request an enrollment form (plan numbers are listed in the comparison charts on page 17).
- Complete and mail the form to the plan.
- You will receive a letter from the plan telling you when your membership begins.
- The plan cannot refuse to enroll you.

To disenroll:

- You may disenroll (leave) a plan at any time for any reason.
- Call the plan or the Social Security Administration (☎) and tell them you want to disenroll.
- Your disenrollment becomes effective as early as the first of the month after your request for disenrollment is received.

How to enroll/disenroll: Medicare Medical Savings Account (MSA) Plan

You can only enroll in a Medicare MSA Plan:

- During the 3-month period before you are entitled to Part A and Part B, or
- During November of each year starting in 1998. **(The first time you enroll in November, you have until December 15 of the same year to change your mind. If you do not change your mind, you must stay in the Medicare MSA for one full calendar year.)**

To enroll:

- Call 1-800-318-2596 and request more Medicare MSA information.
- You set up a special Medicare MSA at a bank/savings institution.
- You choose from among available Medicare MSA plans.
- Your enrollment will be effective January 1.

To disenroll:

- You can leave the Medicare MSA Plan by filing a request for disenrollment in November. Your disenrollment will be effective December 31.

Special rules may apply if you choose to disenroll from a health plan and return to your Supplemental Insurance Policy or your employer's health insurance policy (see page 26).

Medicare Bill/Medicare Coverage/Fraud and Abuse

If you have a question about...	Then you should call...	Who is...	The phone number is...
Your bill or Medicare coverage for Part B: □ doctor services. □ outpatient care. □ other medical services.	Your Medicare Carrier.	Blue Cross/Blue Shield of North Dakota.	1-800-444-4606
Your bill or Medicare coverage for Part A: □ hospital care. □ skilled nursing facility care.	Your Fiscal Intermediary (FI).	Blue Cross/Blue Shield of Washington and Alaska.	1-425-670-1010
Your bill or Medicare coverage for: □ home health care. □ hospice care.	Your Regional Home Health Intermediary (RHHI).	Blue Cross of California.	1-818-593-2009
Your bill or Medicare coverage for durable medical equipment such as wheelchairs, hospital beds, and walkers. Where to get a list of Medicare approved suppliers of this equipment.	Your Durable Medical Equipment Regional Carrier (DMERC).	CIGNA Medicare.	1-800-899-7095
How to sort through/understand medical bills you have received.	Your State Health Insurance Advisory Program.	Statewide Health Insurance Benefits Advisors (SHIBA).	1-800-397-4422 1-206-654-1833
How to recognize Medicare fraud and abuse. How to report Medicare fraud and abuse.	Your Medicare Carrier OR Office of the Inspector General.	Office of the Inspector General.	1-800-HHS-TIPS (1-800-447-8477) TTY for the hearing and speech impaired: 1-800-377-4950

Lost Card/Address Change/Getting Medicare/Other Health Insurance/Other Benefits

If you have a question about...	Then you should call...	Who is...	The phone number is...
A lost Medicare card or address change. Social Security benefits. Supplemental Security Income (SSI) benefits. Applying for (enrolling in) Medicare. The Medicare premium amount deducted from Social Security check.	Social Security Administration.	Social Security Administration.	1-800-772-1213 TTY for the hearing and speech impaired: 1-800-325-0778
Eligibility for Medicaid (Medicaid is a State run program that provides medical help for certain individuals with low incomes and limited assets). A Medicaid Claim.	Your State Medical Assistance Office (Medicaid)*. *Which may also be referred to as a State Medicaid Office, Social Services, Public Assistance, Human Service, Community Services, etc. - names vary from State to State.	Medical Assistance Administration Department of Social and Health Services.	1-800-562-3022
Supplemental Insurance Policies (Medigap or Medicare SELECT) available in your area.	Your State Insurance Department.	Insurance Department.	1-360-753-3613 1-800-562-6900
How/whether to purchase additional health insurance (such as Supplemental Insurance Policies [Medigap] or long-term care insurance).	Your State Health Insurance Advisory Program.	Senior Health Insurance Benefits Advisors (SHIBA).	1-800-397-4422 1-360-407-0383

Complaints/Appeals/Other Medicare Rights/Your Medicare Health Plan Choices

If you have a question about...	Then you should call...	Who is...	The phone number is...
Understanding how to appeal payment denials. Understanding your Medicare rights and protections. How to submit a complaint about medical care or treatment.	Your Medicare health plan, or State Health Insurance Advisory Program.	Statewide Health Insurance Benefits Advisors (SHIBA).	1-800-397-4422 1-360-407-0383
A complaint about the quality of care you received from your doctor, hospital, nursing home, or Medicare health plan.	Your Peer Review Organization (PRO).	PRO-West.	1-800-445-6941 TTY 1-800-251-8890
A complaint about the quality of care you received from your kidney dialysis facility.	End-Stage Renal Disease (ESRD) Network Organization.	ESRD Organization No. 16, Northwest Renal Network.	1-206-923-0714
Any complaint you want to report directly to HCFA.	Your HCFA Regional Office.	Seattle Regional Office.	1-206-615-2354
Discrimination. Equal access to health care.	Office for Civil Rights.	Office for Civil Rights.	1-206-615-2290 TDD 1-206-615-2296
Choosing a Medicare health plan. Deciding between Original Medicare Plan and another Medicare health plan. Understanding your new Medicare health plan choices.	State Health Insurance Advisory Program.	Statewide Health Insurance Benefits Advisors (SHIBA).	1-800-397-4422 1-360-407-0383
Finding out about local seminars and health fairs on your new health plan choices.	Your HCFA Regional Office.	Seattle Regional Office.	1-206-615-2354
Finding out whether you can continue to see your doctor if you join a specific Medicare health plan.	Your doctor.		

Special HCFA Contact Numbers/Railroad Retirement Board (RRB)

If you have a question about...	Then you should call...	Who is...	The phone number is...
Medicare Medical Savings Account (MSA) Plans.	Medicare MSA Information Line.	Medicare MSA Information Line.	1-800-318-2596 TTY 1-877-486-2048
How to Order Medicare Publications, such as *The Guide to Health Insurance for People with Medicare.*	Medicare Hotline.	Medicare Hotline.	1-800-638-6833
How to order a Spanish copy of *Medicare & You.*	*Medicare & You* Order Line.	1-800-MEDICARE	1-800-633-4227 TTY 1-877-486-2048
How to order audio-tapes of *Medicare & You* (English or Spanish).	¿Necesita usted una copia en Español o en audio-cassette del manual de *Medicare y Usted?* Llame gratis a Medicare: 1-800-633-4227		
Railroad Retirement Beneficiaries Only Your bill or Medicare coverage for: □ doctor services. □ outpatient care. □ other medical services.	Your RRB Medicare carrier.	United HealthCare.	1-800-833-4455
Your bill or Medicare coverage for: □ hospital care. □ skilled nursing facility care. □ home health care. □ hospice care.	Your Fiscal Intermediary (FI).	See page 19a.	See page 19a.
Railroad Retirement Beneficiaries Only □ Railroad Retirement benefits. □ Social Security benefits. □ Applying for (enrolling in) Medicare. □ The Medicare premium amount deducted from Railroad Retirement checks. □ Lost Medicare card or address change.	Railroad Retirement Board.	Railroad Retirement Board.	Call the nearest RRB field office or 1-800-808-0772.

Worksheet for Comparing Medicare Health Plans

Medicare doesn't pay for everything, and Medicare doesn't cover everything. To get more coverage, you may purchase a Medicare Supplemental Insurance Policy (see pages 29-30), or you may consider joining a different Medicare health plan, which may provide you with extra benefits.

All Medicare health plans must provide all Medicare covered services described on pages 6-8.

You may choose from many types of health plans. There may be real differences among them, such as cost, choice of providers, extra benefits, quality, paperwork, complaints, and convenience. Use the worksheet on pages 20-25 to ask questions and compare answers. The information you gather will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers from each plan to keep a record.

Each worksheet section begins with important information about the Original Medicare Plan and about the differences among the Medicare health plans.

All of the Medicare health plans approved by the Health Care Financing Administration (HCFA) have met a wide variety of standards. However, HCFA does not rate its plans. You can compare plans with the information you get from this handbook and the plans themselves. Your doctor, friends, and relatives also may be able to help you make your choice. Your decision should be based on your health care needs and personal preferences.

Cost

In all Medicare health plans, including the Original Medicare Plan, you must pay the monthly Part B premium.

In the Original Medicare Plan, you must pay additional costs such as hospital deductibles and coinsurance. The Original Medicare Plan does not pay for prescription drugs. You may be able to cover these out-of-pocket costs by purchasing a Supplemental Insurance Policy or by joining one of the other Medicare health plans. The additional costs with these health plan choices depend on the plan's monthly premium (if any), copayments, and whether providers are allowed to bill extra. Costs vary from plan to plan.

In some Medicare health plans, you must get all covered services from doctors and hospitals that belong to the plan. **If you are in one of these plans, you may get services from doctors or hospitals outside your Medicare health plan, but you will be responsible for paying for these services. The exception is an emergency, or when you require urgently needed care and are out of the health plan's service area. Emergency and urgently needed care are described on page 26.**

Write the plan names in the blocks below.

Call the Plan. Does the plan...	Plan:	Plan:	Plan:
Charge a premium in addition to the Medicare Part B premium?			
Charge copayments for doctor visits?			
Pay for prescriptions? How much?			
Charge more if I use a doctor or hospital outside the plan? How much?			
Have maximum amounts it will pay for different services?			
Set limits on what doctors and hospitals charge you?			
Charge a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services?			

Doctors, Hospitals, and Other Health Care Professionals

In the Original Medicare Plan and the Original Medicare Plan with a Supplemental Insurance Policy, you may use any provider who accepts Medicare. Private Fee-for-Service Plans provide similar choice. In a Medicare MSA plan, you may be able to go to any doctor or hospital, or you may be limited to a network of providers. Many Medicare Managed Care Plans require that you use the plan's doctors, hospitals, and other health care providers. They also may require a referral from your primary care doctor to a specialist. Some allow you to visit certain specialists within the plan—like optometrists, gynecologists, or psychiatrists—without a referral. If you like your current doctor, first ask if he or she belongs to any of the plans you are considering.

Call the plan, and ask...	Plan:	Plan:	Plan:
Are my doctors in the plan?			
Is there a selection of the doctors, health professionals, and hospitals that I might need?			
Can I get the doctor I want? Is he/she accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What's the plan's policy if it does not have the type of specialist I need?			

Extra Benefits

The types of services described in this section are in addition to services that are part of the covered services provided in the Original Medicare Plan. Supplemental Insurance Policies, Medicare Managed Care Plans, and Private Fee-for-Service Plans often provide benefits not provided under the Original Medicare Plan.

Call the plan. Does the plan cover/provide...	Plan:	Plan:	Plan:
Routine physicals?			
Eye exams, glasses, contacts?			
Hearing exams and hearing aids?			
Dental exams/treatments?			
Programs that focus on helping members with specific, chronic conditions such as asthma, diabetes, or heart conditions?			
Programs that address needs like respite care, care giver services, and other social services?			
Wellness programs and classes that help me lose weight, eat properly, stop smoking, or exercise appropriately? Is there any charge?			
Other benefits you may be interested in:			

Prescription Drugs - An Important Extra Benefit

Generally, the Original Medicare Plan does not cover prescription drugs. Some Supplemental Insurance Policies help with the cost of prescription drugs, and some Medicare health plans may cover some of the cost for prescription drugs.

Call the plan, and ask...	Plan:	Plan:	Plan:
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order pharmacies available?			
What is the annual or quarterly dollar limit on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the drugs it pays for to those on a list of drugs (called a formulary)?			

Quality

All Medicare doctors must be licensed in their State. Medicare certifies hospitals, nursing homes, and suppliers. Medicare also requires that Medicare Managed Care Plans establish quality assurance programs to get a Medicare contract. Once operating, Medicare Managed Care Plans must meet standards set by State and Federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in a Medicare health plan.

1) Accreditation. This is an additional seal of approval by a private independent non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.

2) Satisfaction surveys. These surveys ask beneficiaries how well they believe a plan meets their needs.

3) Performance measures. These are special reports that describe the provision of care, such as whether a plan regularly provides mammograms for women. In late 1998, some of these reports will be available on the Internet at www.medicare.gov.

Ask...	Plan:	Plan:	Plan:
The plan: Is the plan accredited by an independent group?			

	Plan:	Plan:	Plan:
Your friends and relatives: Do they like the plan? Do they get the care they need, when they need it?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys? (You can get some of this information on the Internet at **www.medicare.gov** in late 1998.)			

Paperwork

For most services, Medicare Managed Care Plans do not require you to file a claim form. With the Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and Medicare MSA Plans, you may have more paperwork. You may have to pay for covered services when you receive them, and then wait to be reimbursed.

	Plan:	Plan:	Plan:
Call the plan, and ask...			
Do I have to file claims myself?			

Complaints

You have a right to appeal many decisions concerning your Medicare benefits. In the Original Medicare Plan, you are entitled to an appeal, in most cases, if you believe Medicare did not pay enough for services, or if you believe that you have inappropriately been denied payment of health care services you received. You can also appeal to a Peer Review Organization if you believe that you are being discharged too soon from a hospital.

To participate in Medicare, each health plan must have an appeal and grievance (complaint) process for members. If you have any concerns or problems with the plan, you have a right to complain. The first step is to contact the plan. If your problem with a service or payment denial is not resolved with the plan, follow the instructions in the "Questions and Answers" regarding appeals on page 27.

	Plan:	Plan:	Plan:
Call the plan, and ask...			
If the plan has a patient advocate/ombudsman to assist members?			
What is the plan's record regarding complaints?			

Convenience

Location, hours of operation, and similar details, may be important to you. Contact each plan to decide if it is convenient for you.

Call the plan, and find out...	Plan:	Plan:	Plan:
Are the hours and location of its doctors, clinics and other health care providers convenient?			
Is my access to emergency care convenient?			
Are the doctors' offices, labs, and other services convenient?			
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline I can call for medical advice?			

Other Medicare Health Plans ▶

Questions and Answers (Q & As)

Q: What are primary care doctors?

A: Primary care doctors are trained to provide basic care. In many Medicare Managed Care Plans, they coordinate and provide most or all of your health care. Many plans require you to see your primary care doctor for a referral to a specialist. When you join a Medicare Managed Care Plan, you may be asked to choose a primary care doctor from among the doctors who belong to the plan. If you already have a doctor you would like to keep seeing, ask your doctor if he or she is in the plan and accepting new patients under that plan.

Q: May I change my primary care doctor? What if my primary care doctor leaves the health plan?

A: Yes, you may change. To change your primary care doctor, check your health plan member handbook for instructions. You may also call the plan's member services number. In some cases, the effective date of such a change may be the end of the current month. If your doctor leaves the plan, you may choose a new doctor in the plan.

Q: What is a referral?

A: A referral is permission from your primary care doctor to see a certain specialist or receive certain services. Some Medicare health plans may require referrals. Important: if you either see a different doctor than the one on the referral, or the service isn't for an emergency or urgently needed care, you may be responsible for the entire bill.

Q: Can I leave a Managed Care Plan or Private Fee-for-Service Plan and return to the Original Medicare Plan?

A: Yes. You may disenroll from a Medicare Managed Care Plan or Private Fee-for-Service Plan any time, for any reason. However, beginning January 1, 2002, disenrollment opportunities will be limited. To disenroll, give a signed written request to the plan, a SSA Office, or the RRB. You must receive services from the plan until you are disenrolled. Your Original Medicare Plan coverage can start as early as the first day of the month after your request is received.

Q: What happens to my Supplemental Insurance Policy (Medigap) if I join a Medicare health plan, drop my Supplemental Insurance Policy, and then later disenroll from the health plan?

A: You can return to your Medigap policy if you dropped it to enroll in a Medicare health plan or a Medicare SELECT policy. **However:** (1) this must be the **first time** that you enrolled in a health plan or a SELECT policy; (2) you must leave the health plan or SELECT policy **within one year after joining;** and (3) after leaving your health plan or SELECT policy, you must choose a Medigap policy **within 63 days.** If you meet these requirements, you can return to your original Medigap policy, if it is still offered, or policies A, B, C, or F (see pages 29, 30 and 32). Call your State Health Insurance Advisory Program for more information (☎).

Q: What is a medical emergency? How do I get emergency care?

A: A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that **you believe** may cause serious danger to your health if you do not get immediate medical care. Your plan is required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. **Your plan must pay for your emergency care and cannot require prior authorization for emergency care you receive from any provider.** You can receive emergency care anywhere in the United States. When you receive emergency care, the doctor or hospital that provides the service will bill either you or your plan. If you receive the bill, give it to your plan, and keep a copy for your own record. Following a medical emergency, your plan must also pay for care you need before your condition is stable enough for you to return to your plan's provider. If your condition lets you return to the plan service area, you will need to get follow-up care from your Medicare Managed Care Plan. You should let your plan know of emergencies as soon as medically possible. If what you believed was an emergency turns out not to be, the plan must still pay. Your plan can require that you pay the entire cost of care received in an emergency room for a problem that you knew was not an emergency. You can appeal a denial of payment for emergency services (see pages 27 and 28).

Q: What is "urgently needed care"? How do I get urgently needed care?

A: Unexpected illness or injury that needs immediate medical attention, but is not life threatening, is urgently needed care. Your primary care doctor generally provides urgently needed care. If you are temporarily out of the plan's service area and cannot wait until you return home, the health plan must pay for urgently needed care.

Q: Does travel affect my health care? How does the health plan handle coverage when I'm not in the service area?

A: If you travel a lot or live in another State part of the year, you should contact the plan and ask if the plan provides coverage for services when you are out of the service area. The Original Medicare Plan does not cover care outside the United States. Some Managed Care Plans and Private Fee-for-Service Plans, as well as some of the more expensive Supplemental Insurance Policies, cover care outside of the U.S. (Railroad Retirement Board [RRB] beneficiaries have different rules. Contact the RRB or RRB carrier for information (☎).)

Q: If I join a Medicare Managed Care Plan or Private Fee-for Service Plan, will I lose any of my Medicare covered services?

A: No. When you enroll in a Managed Care Plan or Private Fee-for-Service Plan, you are still entitled to all the covered services of the Medicare program. All Medicare Managed Care Plans and Private Fee-for-Service Plans must provide, at least, all the services covered under the Original Medicare Plan. This includes Part A (Hospital Insurance) and Part B (Medical Insurance). Hospice benefits are provided by a Medicare approved hospice in your service area. Medicare Managed Care Plans and Private Fee-for-Service Plans also may provide additional benefits.

Q: How do I question or appeal a Medicare Managed Care Plan or Private Fee-for-Service plan or Medicare Medical Savings Account Plan coverage decision?

A: You have a right to appeal many decisions about your Medicare covered services. You have this right whether you are enrolled in a Medicare Managed Care Plan, Private Fee-for-Service Plan, or a Medicare Medical Savings Account Plan. Your health plan must provide you with written instructions on how to appeal. You may file an appeal if your health plan denies a service, or terminates or refuses to pay for services that you believe should be covered. After you file an appeal, the health plan reviews its decision. Then, if your health plan does not decide in your favor, the appeal automatically goes to an independent review organization that contracts with Medicare. You may be eligible for a fast decision (within 72 hours) if your health or ability to function could be seriously harmed by waiting the amount of time needed for a standard decision. See the health plan's membership materials or contact your health plan for details about your Medicare appeal rights.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO) (☎). During the immediate review, you may be able to stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

Q: Can I find out how a Medicare Managed Care Plan pays its doctors?

A: Medicare Managed Care Plans' current members and those interested in joining the plan have a legal right to know (in writing) how the plan pays its doctors. If you want this information, call the plan.

Medicare Patients' Rights

As a Medicare beneficiary you have certain guaranteed rights that:

- Protect you when you get health care.
- Assure your access to needed health care services.
- Protect you against unethical practices.

They protect you whether you are in the Original Medicare Plan or one of the Medicare health plans now available to you. Your rights include, but are not limited to:

The Right to Receive Emergency Care: If you have severe pain, an injury, sudden illness, or a suddenly worsening illness that you believe may cause your health serious danger without immediate care, you have the right to receive emergency care.

- You never need prior approval for emergency care.
- You may receive emergency care anywhere in the United States.

The Right to Appeal the Original Medicare Plan's or Your Medicare Health Plan's Decisions About Payment or Services: If you are in the Original Medicare Plan, you have the right to appeal a denial of payment for a service you have been provided. Likewise, if you are enrolled in one of the other Medicare health plans, you have the right to appeal the plan's denial for a service to be provided. As a Medicare beneficiary you always have the right to appeal these decisions.

The Right to Information About All Treatment Options: You have the right to information about all your health care treatment options from your health care provider. Medicare forbids its health plans from making any rules that would stop a doctor from telling you everything you need to know about your health care, including treatment options. If you think your Medicare health plan may have kept your health care provider from telling you everything you need to know about your health care treatment options, you have a right to appeal.

The Right to Know How Your Medicare Health Plan Pays Its Doctors (You must request this information.):

- If you request information on how a Medicare health plan pays its doctors, the plan must give it to you in writing.
- You have the right to know whether your doctor has a financial interest in a health care facility (such as a laboratory) since it could affect the medical advice he or she gives you.

Supplemental policies ▶

Supplemental Policies

If you choose the Original Medicare Plan rather than a Managed Care Plan or Private Fee-for-Service Plan, you may decide that you need more coverage than Medicare provides. **Supplemental Insurance Policies only work with the Original Medicare Plan.** Many private insurance companies sell Medicare Supplemental (Medigap) Insurance Policies for the specific purpose of filling the "gaps" in Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health plan. Other types of insurance may also be available to you (see page 31).

Medicare Supplemental (Medigap) Insurance ▶

In all States except Minnesota, Massachusetts, and Wisconsin, Federal law forbids insurers from selling you Medicare Supplemental (Medigap) Policies that are not one of 10 standard supplemental policies. These 10 types of policies must be labeled with the letters A through J, to make it simple for consumers to compare policies. State law may limit the types of policies that are actually sold in your State.

These policies may pay for some or all of the Medicare coinsurance amounts; some or all deductibles; and certain services not covered by the Original Medicare Plan at all. These may include outpatient prescription drugs, some preventive screenings, some care in your home, and emergency medical care for travel outside the United States. Some policies provide coverage of health care provider charges over the amount Medicare will pay.

Medicare SELECT ▶

Medicare SELECT refers to a type of Medigap Policy. It must meet all of the requirements that apply to a Medigap Policy, and it must be one of the 10 prescribed benefit packages. The only difference is that a Medicare SELECT Policy may require you to use doctors and hospitals within its network in order for you to be eligible for full benefits. Because of this limitation, a Medicare SELECT Policy will generally have a lower premium than a regular Medigap Policy.

The types of Supplemental Insurance Policies are listed on the next page.

For more information on Medicare Supplemental Insurance Policies, get a copy of *The Guide to Health Insurance for People with Medicare* or contact your State Health Insurance Advisory Program (☎).

Supplemental Insurance (Medigap or Medicare SELECT) Comparison Information

The following chart is provided to assist you in comparing the Original Medicare Plan with Supplemental Insurance Policies to the Medicare health plan choices shown on page 17. The benefits offered by these policies are not completely described. For more complete information, you can request a copy of *The Guide to Health Insurance for People with Medicare*, or call your State Health Insurance Advisory Program (☎).

What's Most Important to You	Supplemental Insurance Policy A	Supplemental Insurance Policies B, C, D, E, F*, G	Supplemental Insurance Policies H, I, J*
COST Doctor Visits	You pay the first $100 only	You pay nothing†	You pay the first $100 only
Inpatient Hospital	You pay $764 for days 1-60, nothing for days 61-90, and $382 per day for days 91-150**	You pay nothing for days 1-60, nothing for days 61-90, and $382 per day for days 91-150**	You pay nothing for days 1-60, nothing for days 61-90, and $382 per day for days 91-150**
PRESCRIPTION DRUGS	You pay 100% for most drugs.	You pay 100% for most drugs.	You pay 50% per prescription. After meeting a $250 per year deductible, Policies H & I cover up to $1,250 of your prescription drugs. Policy J covers up to $3,000 of your prescription drugs.
EXTRA BENEFITS Physical Exams	Physical Exams not covered.	Physical Exams not covered except under Policy E.	Physical Exams not covered except under Policy J.

* New high deductible policies will become available in most States beginning in 1998. Some supplemental policies may not be available in your state.

** If you have exhausted your 60 lifetime reserve days (see page 6).

† Policies C, F, and J pay the first $100.

Doctor Choice:

Medigap - You may see any doctor, specialist, or provider who accepts Medicare.

Medicare SELECT - You must use plan hospitals and, in some cases, plan doctors to be eligible for full benefits.

Premiums: In addition to your Part B premium, you will pay a Supplemental Insurance Policy premium. These premiums vary by State and usually by age. In general, Supplemental Policies A, B, and C are less expensive than H, I, and J. Policies D, E, F, and G are usually in between.

Vision: Cataract related benefits only.

Dental: In general, you are not covered for dental services.

Employer and Union-Provided Health Insurance: Some employer and union-provided health insurance policies can continue or switch over to provide coverage for you when you are 65 and retired. Contact your former employer or union for information on your plan.

Medicare has special rules that apply to beneficiaries who have group health plan coverage through their own or their spouse's **current employment.** Group health plans of employers with 20 or more employees must offer these people the same health insurance benefits under the same conditions that younger workers and spouses receive. If your group health plan (participation is based on current employment) denies you coverage, or offers you different coverage, call your State Insurance Department (☎).

If you or your spouse stops working and you are already enrolled in Part B:

- Notify your Medicare carrier by phone or in writing that you or your spouse's employment situation has changed (☎).
- Give the carrier the name and address of the employer plan, your policy number with the plan, the date coverage stopped, and why.
- When receiving health care services, tell the provider that Medicare is now your primary payer and should be billed first. Give the date your group health coverage stopped.

If you have employer or union-provided health insurance and disenroll from that group health plan to join another Medicare health plan, you may or may not be able to get the same policy back for the same premium.

Other Types of Private Insurance

The following types of private insurance don't work with Medicare, but may help pay for services not covered by Medicare health plans, such as custodial care. However, these policies should not be confused with Medicare Supplemental Insurance Policies (Medigap), which are required by Federal law to meet certain minimum standards for your protection.

Long-Term Care Insurance can help pay for skilled nursing care or custodial care by paying a cash amount for each day of covered nursing home or at-home care. For a free copy of *A Shopper's Guide to Long-Term Care Insurance*, write to: National Association of Insurance Commissioners (NAIC), Publications Dept., 120 West 12th Street, Suite 1100, Kansas City, MO 64105, or call your State Health Insurance Advisory Program (☎).

Hospital Indemnity Policies pay cash amounts to you for each day of inpatient hospital services.

Specified Disease Policies pay for services only when you need treatment for the insured disease.

Q: What is a Private Contract, and what does it mean?

A: A Private Contract is a contract between a Medicare beneficiary and a doctor or other practitioner who has decided not to provide services through the Medicare Program (not bill for any service or supplies to any Medicare beneficiary for at least 2 years). Under a Private Contract:

- **No Medicare payment will be made for the services you receive.**
- You will have to pay whatever the doctor or practitioner charges you with no limit on the charges (the limiting charge will not apply).
- Medicare Managed Care Plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- If you have a Supplemental Insurance Policy, it will not pay anything for this service. Contact your insurer before you receive the service.
- Many other insurance plans also will not pay for the service.

The Private Contract only applies to the services provided by the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Advisory Program (☎) before signing a Private Contract. If you want to pay on your own for services the Original Medicare Plan doesn't cover, your doctor does not have to leave Medicare or ask you to sign a Private Contract. You are always free to obtain non-covered services on your own if you choose to pay for the service yourself.

Q: If I lose my health plan coverage will I be able to get a Supplemental Insurance Policy?

A: If you lose your health plan coverage under certain circumstances, you will have a right to purchase a Medigap Policy (A, B, C or F) that is sold in your State, as long as you apply within 63 days of losing your other health coverage. Special protections apply for pre-existing conditions. The circumstances include the following:

- Your Medicare Managed Care Plan, Medicare MSA Plan, or Private Fee-for-Service Plan terminates or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its obligations to you.
- You were in an employer health plan that terminated coverage.
- Your Supplemental insurer terminates your policy (and you're not at fault).

Q: When would other insurance pay first? (Medicare would be a secondary payer.)

A: All Medicare payments are made on the condition that you will pay Medicare back if benefits could be paid by insurance that is primary to Medicare. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance, and workers' compensation. Call your Medicare carrier or Fiscal Intermediary (☎).

Q: What is an Advance Beneficiary Notice (ABN)?

A: There are two situations in which a doctor **must** give you an Advance Beneficiary Notice (ABN) in writing. One is before he or she gives you a service that he or she knows or believes Medicare doesn't consider medically necessary, and the other is when he or she knows or believes that Medicare will not pay for the service. If you are not given an ABN before you get the service, you are not responsible for paying for that service. But, if you do receive written notice, sign an agreement, receive the service, and Medicare does not pay for the service, then you must pay for it.

Q: What is Medicaid?

A: Medicaid is a joint Federal and State program that provides payment for some medical costs for certain individuals who are older, have low incomes and limited assets, or are disabled. Coverage and eligibility vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

Q: How can Medicaid help low-income Medicare beneficiaries?

A: Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain older, low-income, or disabled individuals entitled to Medicare Part A. If you do not have Part A or do not know if you are eligible, check with your local Social Security office, or call 1-800-772-1213.

If you have Part A, and your bank accounts, stocks, bonds, or other resources do not exceed $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a **Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB),** or **Qualifying Individual (QI)**.

	Monthly Income Limit*		
	Individual	Couple	Benefit - Pays Medicare's
QMB	$ 691	$ 925	Premiums, deductibles, and coinsurance
SLMB	$ 825	$1,105	Part B premium
QI-1	$ 926	$1,241	Part B premium
QI-2	$1,194	$1,603	Part of the Part B premium

If you think you may qualify, contact your State, county, or local medical assistance office (☎) - not a Federal office.

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 1999.

HCFA publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by telephone (☎) or on the Internet at **www.medicare.gov.**

Q: How are my bills (claims) paid in the Original Medicare Plan?

A: When you receive services covered by the Original Medicare Plan, your provider sends the bill (claim) to a private insurance company that contracts with Medicare. These companies are called the Fiscal Intermediary (for Part A services) or the Medicare carrier (for Part B services). After they process the claim, you receive a Medicare Summary Notice (MSN), or an Explanation of Medicare Benefits (EOMB) (for Part B services) or a Medicare Benefits Notice (for Part A services).

You have a right to request an itemized statement from the provider of the service. You must receive it within 30 days of your request. Please check the notice to be sure you were not billed for services, medical supplies, or equipment that you did not receive. If you have any questions about bills or services listed on the notice, contact the carrier or Fiscal Intermediary (the name and phone number are on the notice). If you disagree with a claims decision, you have the right to file an appeal. The notices tell you how to file an appeal. See below.

Q: How do I appeal a Medicare payment or coverage decision under the Original Medicare Plan?

A: If you are dissatisfied, you have a right to appeal any decision concerning your Medicare covered services in the Original Medicare Plan. You can file an appeal if you believe Medicare did not pay enough for services or should have paid for health care services you received. Your appeal rights will be detailed on the back of the Medicare Summary Notice (MSN) or Explanation of Medicare Benefits (EOMB) that is mailed to you.

Q: What can I do if I think I'm being discharged from the hospital too soon?

A: If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO) (☎). You can stay in the hospital at no charge and cannot be discharged before the PRO makes a decision.

Q: Are there rules that protect me in a Skilled Nursing Facility (SNF)?

A: Every Medicare Skilled Nursing Facility (SNF) must meet quality standards. They can't require you to pay a deposit or other payment to be admitted to the facility unless it is clear that Medicare does not cover the cost of services. If the SNF staff decides you don't need the level of skilled care covered by Medicare, you must be told immediately. If you disagree with this decision, the SNF must request an official Medicare decision on coverage. The SNF can't require you to pay a deposit for services that Medicare may not cover until Medicare gives its decision. You must pay for any coinsurance while your claim is being processed, and for services not covered by Medicare. If you have questions about SNF care, contact your Fiscal Intermediary (☎).

Fraud and Abuse

Medicare is improving its capability to crack down on those who take advantage of this program. We are using four methods to fight fraud and abuse: prevention, early detection, coordination with other government agencies, and prosecution of wrongdoers.

We need your help to make this work. Every year millions of dollars are stolen from Medicare, and beneficiaries pay for it with higher premiums. You can help protect Medicare and yourself by reporting all suspected instances of fraud and abuse.

Whenever you receive a payment notice from Medicare, review it for errors. Make sure Medicare did not pay for services, medical supplies, or equipment that you did not receive.

If you have a questionable charge on your bill, call the provider, your Fiscal Intermediary (for Part A bills) or your Medicare carrier (for Part B bills). If you believe that a health care provider may be cheating or abusing the Medicare program, call the Medicare carrier or intermediary that sent you the payment notice. The carrier's or intermediary's name, address, and telephone number will be on the payment notice.

You may also call the Inspector General's hotline to report suspected cases of fraud (☎).

Medicare will not disclose your name if you request confidentiality.

Protect Yourself Against Health Care Fraud

- ☐ Never give your Medicare or Medicaid number over the telephone or to people you do not know.
- ☐ Beware of providers and suppliers that use phone calls and door-to-door selling as a way to sell you goods or services.
- ☐ Be suspicious of companies that offer free medical equipment or offer to waive your co- payment without first asking about your ability to pay.
- ☐ Beware of health care providers who say they represent Medicare or a branch of the Federal government, or providers who use pressure tactics to get you to accept a service or product.

Discrimination

Every facility or agency that participates in Medicare must comply with the law. Laws ban discrimination on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Office for Civil Rights in your State (☎).

Advance Beneficiary Notice (ABN) 33
Ambulance 5, 7
Appeals (Original Medicare Plan) 34
Appeals (Other Medicare Health Plans) 13, 24, 27, 28
Assignment 5
Assistance - Whom to Call 19a-d
Audio-tape of *Medicare & You* 19d
Barium Enema 8
Benefit Period 6
Bills (Claims) 34
Blood 6, 7
Bone Mass Measurement 8
Booklets/Pamphlets from HCFA 19d
Coinsurance 2, 4
Colonoscopy 8
Colorectal Cancer Screening 8
Comments ..... Table of Contents
Copayments 4
Covered Services (Part A and B) 6, 7, 8
Deductible 2, 4, 6, 7
Diabetes Monitoring 8
Discrimination 35
Disenrollment 18
Eligibility (Part A and B) 2, 3
Employer or Union Provided Health Insurance 11, 29, 31
End-Stage Renal Disease 9, 11
Enrollment 2, 3, 18
Explanation of Medicare Benefits (EOMB) 34
Fiscal Intermediary 2, 6, 34
Flexible Sigmoidoscopy 8
Flu Shots 8
Foreign Travel 27, 29
Fraud and Abuse 35
Health Plan Choices 1, 9-25
Hepatitis B Vaccination 8
Home Health Care 6, 7
Hospice Care 6
Hospital Discharge 34
Hospital Indemnity Policies 31
Hospital Stays 6
Internet 1
Introduction to Learning About Health Plans 9
Laboratory Services 7
Limiting Charge 5
Long-Term Care Insurance 31
Mammogram 8
Managed Care Plans 11, 15, 18, 27
Health Maintenance Organization (HMO) 11, 15
Point of Service Option (POS) 11, 15
Preferred Provider Organization (PPO) 11, 15
Provider Sponsored Organization (PSO) 11, 15
Medicaid 4, 5, 11, 33
Medicare as a Second Payer 32
Medicare Benefits Notice 34
Medicare Bills (Claims) 34
Medicare Carrier 3, 7, 34
Medicare Health Plans 1, 11, 14-16
Appeals 27, 28
Joining (Enrollment) 18
Medical Emergency 26, 28
Primary Care Doctor 25
Referrals 25
Service Area 9
Travel 27
Urgently Needed Care 26, 28
Medicare Medical Savings Account Plans 11, 16, 18
Medicare Patients' Rights 28
Medicare Summary Notice (MSN) 34
Original Medicare Plan 2, 14
Hospital Insurance (Part A) 2, 6
Medical Insurance (Part B) 3, 7
Prevention Services 8
With a Supplemental Insurance Policy 11, 14
Out-of-Pocket Costs 4, 9
Outpatient Hospital Services 7
Pap Smear 8
Part A 2, 6
Part B 3, 7
☎ Phone Numbers for Assistance 19a-d
Plan Comparison Information 17
Pneumococcal Vaccination 8
Premium 2, 3, 12-16
Prescription Drugs 4, 7, 13, 23
Preventive Services 8
Primary Care Doctor 25
Private Contract 32
Private Fee-for-Service Plans 11, 15, 18
Private Supplemental Insurance Policies 29-31
Qualified Medicare Beneficiary Program 33
Qualifying Individual Program 33
Railroad Retirement Beneficiaries (RRB) ..... Table of Contents
Referrals 25
Religious Fraternal Benefit Society Plans 11, 16
Skilled Nursing Facility Care 6, 34
Spanish Version *Medicare & You* 19d
Specified Disease Policies 31
Specified Low-Income Medicare Beneficiary Program 33
Steps to Choosing a Health Plan 10-18
Supplemental Insurance Policies
Medicare SELECT 14, 26, 29, 30, 32
Medigap 14, 26, 29, 30, 32
Union Insurance 11, 29, 31
Veterans 11
Worksheet 20-25

Index

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There may have been changes to the health plan information listed on pages 17a-g. If you are thinking about choosing a health plan, please call 1-800-633-4227 or TTY 1-877-486-2048 to request updated information on health plans available in your area.

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Your copy of *Medicare & You* has information on the Medicare health plan choices you are eligible for and those that are currently available in the area where you live.

Audio-tapes in English and Spanish, and Spanish copies of *Medicare & You* are available (see page 19d).

¿Necesita usted una copia en Español o en audio-cassette del manual de *Medicare y Usted*? (Véase la página 19d.)

Sharing *Medicare & You:* Households with up to four Medicare beneficiaries will get one handbook to share to help conserve Medicare funds. All other beneficiaries in each household will receive postcards with information on how to get an extra handbook if needed.

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